Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

J THOMAS DILGER JR MD
6718 MONTAY BAY DR
SPRING TX 77389

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-0165-01

MFDR Date Received
SEPTEMBER 18, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with their request for medical fee dispute resolution.

Amount in Dispute: $1,000.00 plus interest

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Chartis has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). In reviewing the report, it is the carrier's position that the dates of service in dispute have already been paid directly to the provider for the amount in dispute. I have attached the EOR's with check numbers and also the payment history screen showing the carrier paid the provider."

Response Submitted by: Chartis, 4100 Alpha Rd., Ste. 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 3, 2011	MMI/IR	$1,000.00 + interest	$20.67

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
2. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §134.130 sets out procedures for Interest for Late Payment on Medical Bills and Refunds..
4. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

5. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008..
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 - 29 – The time limit for filing has expired.
   - 1 – Date(s) of services exceed (95) day time period for submission per RULE 408.027 and Bulletin No. B-0037-05A.
   - Our position remains the same. If you disagree with our decision, please contact the TWCC Medical Dispute Resolution.
   - Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.

Issues

1. Was the timely filing deadline applicable to the medical bills for the services in dispute?
2. What is the Maximum Allowable Reimbursement (MAR) for CPT Codes 99456-WP-W5; 99456-WP-W5 (second area) and 99456-RE-W6?
3. What is the interest due per 28 Texas Administrative Code §134.130?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Review of the documentation submitted by the requestor finds that the requestor submitted the medical bill to the respondent on November 5, 2011 by fax to 866-739-6983 as supported by the transmission verification report. According to the respondent they reprocessed the bill on July 26, 2012; this was confirmed by the requestor on December 1, 2012. The insurance carriers' denial reason of 29 is not supported.
2. The requestor billed the amount of $1,000.00 for CPT Codes 99456-WP-W5 in the amount of $350.00; 99456-WP-W5 in the amount of $150.00 and 99456-RE-W6 in the amount of $500.00. Per 28 Texas Administrative Code §134.204(j)(3)(c); (j)(4)(C)(ii)(I) and (n)(21) review of the documentation supports that the doctor assigned MMI and determined the extent of injury and was reimbursed by the respondent and that the complete medical bill was submitted to the insurance carrier on November 5, 2011.
3. The respondent reimbursed the requestor the amount of $0.00 for interest due. In accordance 28 Texas Administrative Code 134.130(a)Insurance carriers shall pay interest on medical bills paid on or after the 60th day after the insurance carrier originally received the complete medical bill, in accordance with §133.340 of this title (relating to Medical Payments and Denials). (c)The rate of interest to be paid shall be the rate calculated in accordance with Labor Code §401.023 and in effect on the date the payment was made. The bill was received by the insurance carrier on November 5, 2011; the insurance carrier reimbursed the requestor on July 26, 2012. The number of days of interest owed is 205 with the interest rate being 3.68%; therefore, the appropriate amount of interest owed to the requestor is $20.67.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $20.67.

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ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $20.67 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		July 31, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.